dell children's HEALTH PLAN

Behavioral Health Discharge Note

Please submit using our preferred method electronically via **www.availity.com*** within one business day of discharge. If you prefer to fax, you may send this form to **1-844-445-6648**.

Today's date:		
Contact information		
Member name:	Subscriber ID:	Member date of birth:
Member address:		Member phone number:
Name of facility:	Facility NPI/Dell Children's Health Plan provider number:	
Date of discharge:	Discharge address:	
Discharge phone #:	Other contact information (for example, mobile phone, family member or guardian):	

Was this discharge against medical advice?	☐ Yes ☐ No
Was discharge information sent to the PCP?	☐ Yes ☐ No
Was discharge plan discussed with member?	☐ Yes ☐ No
If required for a minor, was informed consent for psychotherapeutic medication completed and given to parent/guardian?	☐ Yes ☐ No

Were any of the following included in the discharge plan? Check all that apply.	**Yes**	**No**	**Accepted**	**Refused**
Skilled nursing facility				
Assisted living facility				
Targeted case management				
Intensive case management				
Therapeutic behavioral on-site services				

Day treatment				
Other (specify)				

Discharge diagnosis (behavioral health and medical)

Discharge medications (Include medications and doses for all conditions.)

Are these medications on the formulary, or do they require prior authorization?
☐ Yes ☐ No

Has precertification been received if needed? ☐ Yes ☐ No

Risk assessment (If yes, explain.)

Was the member stable at discharge? (No risk for suicide/homicide/psychosis)

Discharge appointment (Must be within seven days.)

Provider name:	Provider phone:
Provider address:	
Tax ID #:	Is this an in-network provider? ☐ Yes ☐ No
Date of appointment:	Time of appointment:
Describe any barriers to patient attending this appointment:	
Submitted by:	Phone number: